COATESVILLE VAMC
HOMELESS SERVICES APPLICATION

Completed form to be faxed to: Admissions Coordinator
CVAMC Domiciliary Office (116D)
1400 Blackhorse Hill Road
Coatesville, PA 19320
Telephone No. 610-384-7711, x2911
Fax No. 610-466-2242

GENERAL

Full Name: _____ **Contact #:** _____

Date of Birth: _____ **SS#:** _____--_____--_____

MILITARY HISTORY (circle all that apply)

- **Years of service:** Year entered _____ Year exit _____
- **Branch (circle one):** Army, Navy, Marines, Air Force, Coast Guard, National Guard, Reserves
- **Active Duty?** YES NO
- **Type of discharge:** Honorable, General, Other than Honorable, Bad Conduct, Dishonorable
- **OEF/OIF/OND:** YES NO

FAMILY SUPPORTS (fully complete all bullet points)

- **Marital status**: Married Remarried Widowed Separated Divorced Never married

  Committed/partnered Declined
- **Number of Children under 18?** _____ **Number of children in your custody?** _____
- **Additional supports?** _____

  _____

Notes:

LIVING SITUATION

1. How long have you been homeless? _____
2. Where did you sleep last night?_____

   _____

Revised: January 9, 2012

3. Have you had any contact with any of the following? (Check all that apply)

_____Shelter system If so, year(s): _____
_____Outreach services If so, year(s): _____
_____VA DOM: If so, year(s): _____
_____ Transitional Housing
(Fresh Start, LZII, Impact) If so, year(s): _____
_____HUD VASH If so, year(s): _____

_____Other homeless programs: List and give year(s) for all that apply: _____

4. Are you able to live and care for yourself (wash, bathe, cook, etc.)? YES NO
If not, why not? _____

5. Why are you unable to sustain housing? _____

6. Do you have your own car? YES NO

7. Do you have valid driver's license? YES NO

8. Where do you want to live after the program? State: _____ County? _____
City: _____ Neighborhood: _____

9. With whom?

_____Relative (please specify): _____
_____Romantic Relationship
_____Friend
_____Myself
_____Other (please specify): _____

Notes:

EMPLOYMENT and INCOME

1. Do you currently have a job? YES NO
If yes, please check all that apply:

_____Full-time _____Part-time _____ Temporary _____ Seasonal _____ Self-employed

2. On a scale of 0 to 10, how important is finding a job?

0 1 2 3 4 5 6 7 8 9 10

(not important) (very important)

3. When was your most recent job? _____ Occupation? _____

4. What are your employment skills? _____
_____

5. On a scale of 0 to 10, how ready are you to work right now?

0 1 2 3 4 5 6 7 8 9 10
(not ready) (very ready)

6. What do you see as barriers to working at this time? _____
_____
_____

ASSETS/month		DEBTS/month	
Employment	$ _____ per month	Housing costs	$ _____ per month
Unemployment	$ _____ per month	Student loans	$ _____ per month
DPA	$ _____ per month	Car expenses	$ _____ per month
VA/SC	$ _____ per month	Child support	$ _____ per month
VA Non/SC pension	$ _____ per month	Alimony	$ _____ per month
SSI	$ _____ per month	Credit Card debt	$ _____ per month
SSD	$ _____ per month	Medical bills	$ _____ per month
Retirement	$ _____ per month	Legal costs	$ _____ per month
Other	$ _____ per month	Taxes	$ _____ per month
Total Savings	$ _____ To date	Other	$ _____ per month

LEGAL HISTORY

1. Any open warrants for your arrest in any state? YES NO
   If yes, offense? _____

2. Do you have any upcoming court dates? YES NO
   If yes, offense? _____
   Date? _____

3. Are you on probation or parole in any state? YES NO
   If yes, offense? _____
   Date off parole? _____

Revised: January 9, 2012

4. For placement purposes only, are you a registered sex offender? YES NO

Incarceration History:

Offense(s)	Date(s) served

HEALTH HISTORY

--Medical History--

1. List any medical history (diabetes, high blood pressure, seizures, etc.):_____
2. Have you ever been hospitalized for any medical problems? YES NO
   If yes, please list hospitalization history (**and dates)**:_____
3. List any past surgeries (include dates):_____
4. List all of your medications: _____
5. Are you taking your medications as ordered? YES NO
   If no, why? _____
6. When was your last Test for Tuberculosis (PPD)?_____ Result: Negative Positive

   If positive, did you receive treatment? YES NO
   What type? _____
7. Have you fallen in the past 3 months? YES NO

If yes, what were the circumstances of the fall? _____

_____

8. Do you use a cane, walker, wheelchair to get around? YES NO
   If yes, type? _____

--Mental Health History--

1. Has a doctor ever told you that you have a mental health diagnosis? YES NO
   If yes, please list: _____

   _____

2. Do you take any psychiatric medications? YES NO
   If yes, list all medications: _____

   _____

   _____

3. Do you take all psychiatric medication as ordered? YES NO
   If not, why not? _____

   _____

4. Have you ever been hospitalized for any mental health problems? YES NO
   If yes, please list mental health hospital history (**and dates)**: _____

   _____

   _____

--Substance Abuse History--

1. Have you ever had a drug and/or alcohol problem? YES NO
   If yes, please list all types used: _____

   _____

   _____

2. When did you last use any drugs and/or alcohol? _____

3. Have you ever been in treatment for substance abuse? YES NO
   If yes, when? _____

   _____

--Homicidal/Suicidal--

1. Have you ever tried to physically hurt yourself? YES NO
   If yes, how (provide dates)? _____

   _____

2. Do you have a Safety Plan? YES NO

3. Have you ever tried to physically hurt someone? YES NO
   If yes, when? _____

Applicant's Signature & Privacy Statement

I affirm that the contents of this application are true and correct to the best of my knowledge, information, and belief.

By: _____ Date: _____

The information you provide on this form will be used for to assist with recommendations for homeless placement. This information will be considered confidential and its confidentiality will be maintained under all applicable rules and regulations of the Department of Veterans Affairs. Your signature on this form provides the Department of Veterans Affairs permission to disclose protected health information (which may include sensitive information such as drug and alcohol treatment, sickle cell anemia and Human Immunodeficiency Virus infection or HIV and/or Acquired Immuno-Deficiency Syndrome or AIDS) orally or in writing to VA and non-VA organizations concerned with your care. If you choose to prohibit communication of this information to non-VA organizations, you must inform your VA health care provider.

REFERRAL INFORMATION

Referral from (Name and Facility): _____

Contact phone: _____

REFERRAL PLAN (to be completed by Homeless Admission Committee only)

Recommend this veteran for the following program(s) (Check all that apply):

_____ Homeless Domiciliary
_____ SARRTP
_____ PTSD
_____ Women's Program (POWER/Walker House)
_____ Fresh Start
_____ Independence Hall
_____ LZII
_____ HUD-VASH
_____ Community Housing
_____ Case Management
_____ Outpatient Treatment
_____ Other

Rationale: _____

Alternative Plan(s):

Additional information needed (List):

Revised: January 9, 2012

DOM AGREEMENT FORM

Read and initial each paragraph and sign at the bottom of sheet.

_____I understand that coming to the Homeless Domiciliary means that **I am agreeing to live independently in the community after discharge**. I understand that my discharge from this program is my responsibility and I will work with my assigned treatment team to explore available resources. I understand housing options may be limited and I must be willing to accept a housing option that may not be my first choice. My refusal to accept a viable housing option may not be used as a reason to extend my length of stay.

_____ I understand that my participation in this program is voluntary and that applicants should have a sincere commitment to recovery and independent living. I understand that medical and psychiatric conditions that can be treated on an outpatient basis will be deferred until after discharge. **The primary goal of my stay in the Homeless Dom is to alleviate my homelessness.**

_____ I understand that I will receive a breathalyzer test for alcohol and a urinalysis for drug screen as part of the screening process and at random times during treatment. I understand that abstinence is a requirement for participation in the Homeless Domiciliary.

_____ I understand that there is an initial BLACK OUT period of at least seven days after admission when I am restricted to VA grounds. The treatment team can decide to extend the Blackout period to insure my safety and positive adjustment to the program.

_____ I understand that the length of stay (LOS) in the program is dependent upon my goals and treatment progress. I understand that FULL PARTICIPATION in all treatment-related activities is expected. I understand that I may be discharged from the program if I am not participating in or benefitting from the program or not making progress on my treatment goals.

_____ I understand that passes (leaving VA grounds for more than 4 hours except for work) need to be requested in advance and I must be in compliance with all aspects of my treatment plan for approval.

_____ I understand job offers may be limited. I must be willing to accept a job or assignment that may not be my first choice. Refusal to accept a viable job offer or available work assignment may not be used as a reason to extend my LOS. I agree to fully participate in job search activities as outlined by my individualized treatment plan.

_____ I understand that I will need to share information about all sources of income, debts, obligations, and savings to the treatment team and I agree to comply with saving a target of **90%** of my income for my future housing. I agree to work with my treatment team to individualize my own personal budget plan and I understand that not following my budget plan will result in early discharge from the program.

_____ I understand that an important part of the program is being part of a therapeutic community which includes other veterans who are also pursuing recovery goals. I understand that while in the program, I am expected to treat all residents and staff with respect. Aggressive, intimidating, discriminatory, or assaultive behavior will NOT be tolerated.

_____ I understand that I will have chores and duties assigned as part of living in the therapeutic community and that I am responsible for maintaining order and cleanliness of my room, belongings, and person while in the program. By admission to the program, I am agreeing to random inspection of my belongings and living area to insure the safety of all residents.

YOUR SIGNATURE INDICATES UNDERSTANDING AND ACCEPTANCE OF THE ABOVE CONDITIONS

Signature:_____ **Date:** _____